MICHIGAN CHILD DEATH REVIEW- CHANGES IN POLICY AND PRACTICE

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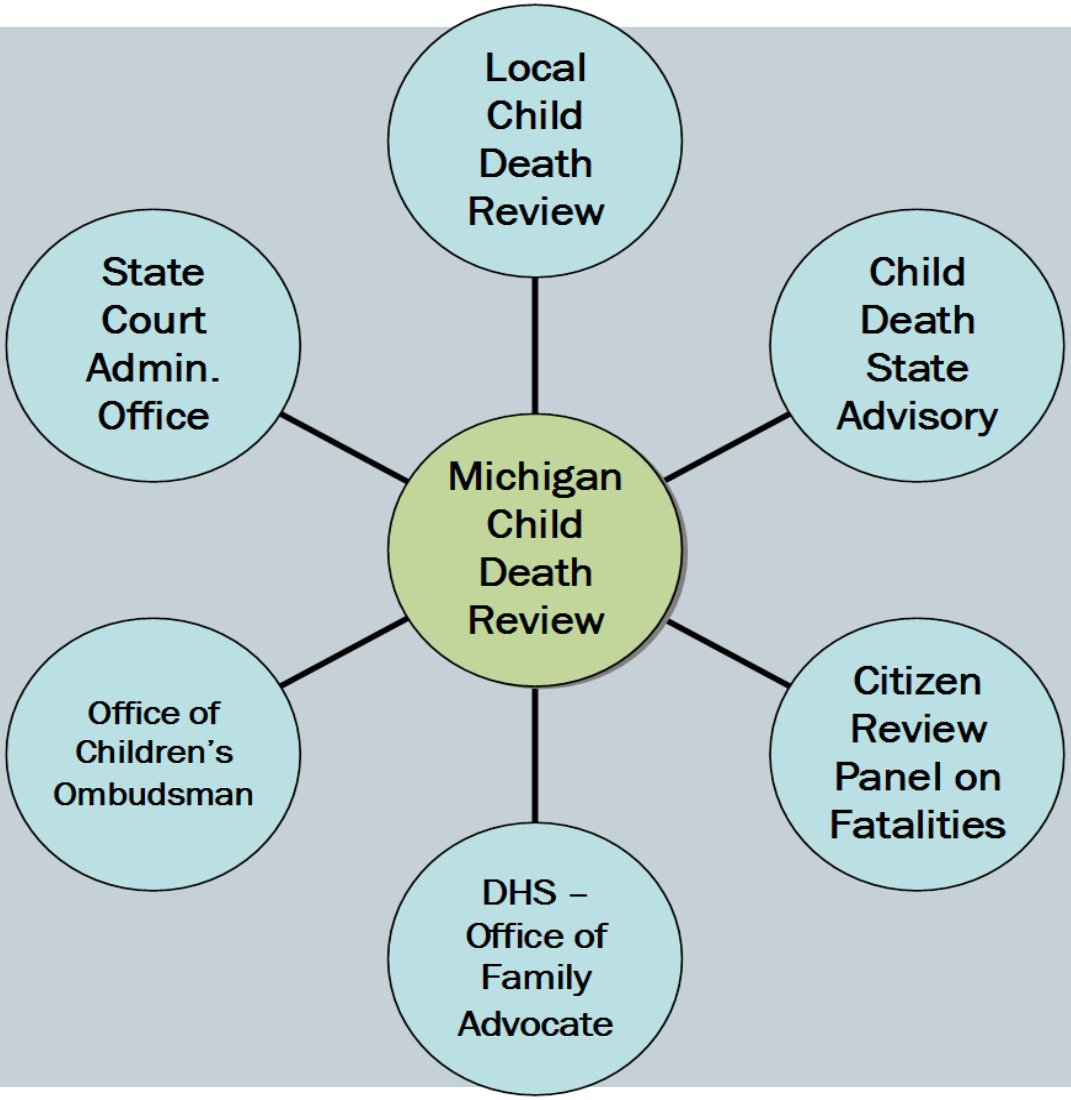
CHILD DEATH REVIEW IN MICHIGAN: INTERAGENCY INVOLVEMENT



LOCAL CHILD DEATH REVIEW TEAMS

- Established as pilot in 1995 with federal grant.
- Enacted into state law in 1999 – all 83 counties.

- Purpose: Use local review findings to improve agency systems and to take action to prevent deaths.

- Focus: From investigation and data collection to identifying strategies to prevent deaths.

- Multidisciplinary

Average 15 members

Mandated Members:
County prosecutor
Court official
Law enforcement
CPS
Public health
Medical examiner

CHILD DEATH REVIEW TEAMS

Accomplishments

- Improved local death scene investigations, protocols
- Drug take-back initiatives
- Coordinated approach to prosecution and service delivery
- Detroit Homicide – now responds to every SUID along with Pediatric Mortality Investigator from ME's office
- Trigger lock giveaway
- Crib and sleep sack giveaways
- Multiple investigations/recalls by the CPSC
- Formation of local youth suicide prevention task forces
- Michigan was 1st state to implement GDL for new drivers

CHILD DEATH STATE ADVISORY TEAM

- Established in state law
- Launched in 1998 to:

"identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts."

CHILD DEATH STATE ADVISORY TEAM

- Meets quarterly
- Discuss mortality data
- Review local CDR findings
- Identify trends
- Initiate prevention opportunities
- Annual Report

Accomplishments

- Safe sleep initiative
- Hospitals and LE implemented protocols for staff to report unexpected infant deaths to CPS
- Graduated Drivers License
- Help to expand local prevention initiatives

OFFICE OF CHILDREN'S OMBUDSMAN

- Established in 1994 as independent "watchdog" over DHS and private agencies.
- 2000 – beating and drowning death of Ariana after court returned her to parents
- Ariana's law – Ombudsman to investigate child deaths that may have resulted from abuse or neglect and make recommendations to prevent future deaths.
- Interagency Agreement between DHS and OCO – DHS death alerts → OCO

OFFICE OF CHILDREN'S OMBUDSMAN

Key Finding: Discrepancies among counties in assign/dispo of complaints when unsafe sleep a factor in death.

Led to:

- ❑ CPS child death checklist
- ❑ Modified CPS policy and training to provide clear, consistent guidelines for workers and supervisors.

- **For example policy clarification:**
  1. When a complaint involving a death must be assigned for investigation, and
  2. What factors must be considered when reaching a CPS disposition involving a deceased child.

CPS Death Policy

Investigation disposition decision

Parent/caregiver's knowledge of the tenets of infant safe sleep and lack of adherence does not constitute child abuse or neglect. When a child death occurs in an unsafe sleep environment, the following must be considered:

- Substance abuse – was the parent/caretaker impaired?
- Supervision – reasonable and appropriate?
- Hazardous environment – did the conditions of the home affect child safety?

DHS – OFFICE OF FAMILY ADVOCATE

The Office of Family Advocate (OFA) developed internal mechanisms for identifying, responding to, and reviewing child deaths reported to CPS.

- Discrepancies across counties in response and disposition
- Lack of internal communications about deaths
- Inability to respond timely to legislators, Ombudsman, media, governor's office, public.
- Inability to accurately report maltreatment deaths to NCANDS

DHS- OFFICE OF FAMILY ADVOCATE

- In 2011: Interagency Agreement with the SCAO to share ward fatality review reports with the court.

http://tinyurl.com/aj54vld

- In 2011: 10-minute webcasts - depicts a different child fatality case each month.
- Summarizes lessons learned, highlights strong practice, encourages adherence to applicable policy.

POLICY, PRACTICE, PROTOCOL

Birth Match

- DHS & DCH cooperation
- Statewide automated system notifies CPS Centralized Intake when a child is born to a parent who had:
  - Prior termination of parental rights
  - Caused death to a child as a result of abuse or neglect, or
  - Had perpetrated egregious abuse to a child, such as sexual abuse or life-threatening injury.
- CPS data system automatically generates a complaint to the local office supervisor.
- The complaint is assigned for investigation.

BIRTH MATCH --- THREATENED HARM

- Threatened harm – Must determine before deciding to file a court petition with a request for termination.

- Harm is **likely to occur** based on:

1. A current circumstance OR
2. A historical circumstance absent evidence that past issues have been **successfully** resolved.

STATE LAW

- Safe Delivery of Newborns law
- Effective January 2001
- Anonymous safe surrender of newborn <72 hours.
- Private adoption agencies assume responsibility.
- Research showed that parents dealing with an unplanned and hidden pregnancy who harmed or abandoned infant did so within 72 hours.
- As of June 2012 – 120 newborns safely surrendered – majority in Detroit Metro area.

POLICY, PRACTICE, PROTOCOL

- 2010 – maltreatment in care unit (Holland Case)

  A separate unit was created within CPS to investigate complaints about children placed in:

  - Licensed foster homes
  - Unlicensed relative placement homes
  - Residential placements
  - Group homes
  - Shelter care

- 2012 Centralized Intake

  Single state office designated for CPS intake statewide

  Ensures consistency in assigning and rejecting complaints.

PREVENTION INITIATIVES

- Initiative was the result of findings from local child death reviews teams, the OFA, and the Citizen Review Panel on child fatalities.
- Led to changes in DHS policy:

  - CPS must investigate if unsafe sleep may have been a factor in the death.
  - CPS must inquire about a parent's knowledge of safe sleep during investigation.
  - Foster care workers must inform, observe, reinforce and document safe sleep at each home visit.
  - Foster home licensing evaluations and adoption family assessments must document caregiver safe sleep compliance.
  - Policy explains how to assess whether unsafe sleep related death was the result of parental neglect or abuse.

SAFE SLEEP zzzzzzzzzzzzzzz

The following initiatives are underway to address unsafe sleep:

- Interagency work plan: DHS and DCH.
- Hiring - permanent safe sleep coordinator.
- Updated video & resource materials.
- Training child day care home licensees.
- Securing financial support for pack-and-play crib distribution.

- Director encouragement for scene re-enactment in each death.
- Require Medicaid providers to inform parents about potential unsafe sleep consequences.
- Interns to make home visits to new parents month 1, 2, and 3 after birth. (Detroit)
- Teaming with hospitals to teach parents safe sleep. (Detroit)

PRESENTER'S CONTACT INFORMATION

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